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86-1.59 Capital expense reimbursement for DRG case based rates of payment. Capital expense shall not include capital expense allocated to exempt units and designated AIDS centers.

(a) The allowable costs of fixed capital (including but not limited to depreciation, rentals and interest on capital debt or, for hospitals financed pursuant to Article 28-B of the Public Health Law, amortization in lieu of depreciation, and interest and other approved expenses associated with both fixed capital and major movable equipment) and major movable equipment shall, with the exception noted in subdivision (c) of this section, be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of sections 86-1.23, 86-1.24, 86-1.29, 86-1.30 and 86-1.32 of this Subpart. In order for budgeted expenses to be reconciled to actual:

(1) Rates of payment for a general hospital shall be adjusted to reflect the dollar difference between budgeted capital related inpatient expenses included in the computation of rates of payment for a prior rate period and actual capital related inpatient expenses for the same prior rate period.

(2) This amount shall be adjusted to reflect increases or decreases in volume for the same rate period.

(3) Capital related inpatient expenses included in the computation of payment rates based on budget shall not be included in the computation of

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a volume adjustment as described in paragraph (a) of section 86-1.64 of this Subpart.

(4) Prospective adjustments shall not be carried forward except for those adjustments authorized in paragraph (a) of section 86-1.64 of this Subpart.

(b) General hospitals shall submit a schedule of anticipated inpatient capital related expenses for the forthcoming year to the commissioner at least 120 days prior to the beginning of the rate year.

(c) [For hospitals whose average budgeted capital expense in 1984, 1985 and 1986 exceeded 110 percent of average actual allowable capital expense for those years, the commissioner shall use the most recently available certified cost report data for purposes of effecting capital cost reimbursement pursuant to this section.] For hospitals whose budgeted capital expenses for the rate year two years prior to the current rate year exceeded actual capital expenses for that same rate year, capital cost reimbursement shall be determined by multiplying rate year budgeted data by the result of dividing actual capital expenses for the rate year two years prior to the current rate year by the budgeted capital expenses for that same rate year and shall be reconciled to total actual expense for the rate year.

(d) The following principles shall apply to budgets for inpatient capital-related expenses:

(1) The basis for determining capital-related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for construction of the capital asset.

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(2) Any capital-related inpatient expense generated by a capital expenditure which requires or required approval pursuant to article 28 of the Public Health Law, must have received such approval for the capital-related expense to be included in the rate calculation.

(3) The submitted budget may include the capital-related inpatient expense of all existing capital assets, as well as estimates of capital-related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year.

(4) Any capital-related expense generated by a capital expenditure acquired or placed in use during a rate year shall be carried forward to the subsequent rate year, provided all required approvals have been obtained. In instances where such approvals have been obtained or where approval is not required and such assets are acquired or placed in use during a rate year, the budget may include estimates for capital-related expenses relating to these assets.

(e) Allocation of budgeted capital costs. In each rate year budgeted capital costs shall be allocated to exempt and non-exempt units and to the Medicare program, to DRG case payment rates, and to payments for transfer patients (other than patients assigned to the transfer DRG's) and short-stay patients as follows:

(1) Allocation to exempt units and to Medicare within exempt units. Budgeted capital costs shall be allocated to exempt units based on reported [1986, 1987, and 1988] exempt unit costs and statistics for [rate years 1988, 1989 and 1990, respectively] the year two years prior to the rate year. The Medicare share of exempt unit capital costs shall be based on budgeted Medicare exempt unit days for the rate year (reconciled to actual rate year days) and the exempt unit's average budgeted capital cost per day, calculated using total budgeted days for the exempt unit. Exempt unit budgeted capital costs shall be reconciled to acutal exempt unit capital costs in the rate year after these data are available.

(2) Allocation to non-exempt units and to non-Medicare DRG case payment rates within non-exempt units and hospitals. The balance of budgeted capital costs, after allocation to exempt units, shall be allocated to non-exempt units. The non-Medicare share of budgeted capital costs in both non-exempt units and non-exempt hospitals shall be based on budgeted non-Medicare non-exempt unit days for the rate year (which, for purposes of this paragraph only, shall exclude short stay and

transferred-out patient days and which shall be reconciled to actual rate year days) and the non-exempt hospital's average budgeted capital cost per day calculated using total non-exempt budgeted days. Budgeted capital costs shall be reconciled to actual capital costs for the non-exempt hospital in the rate year after these data are available based upon the non-Medicare share of capital costs derived by subtracting Medicare capital costs from total capital costs. Medicare capital costs shall be determined by applying the relationship of Medicare ancillary charges to total ancillary times total inpatient ancillary capital costs. Total Medicare capital shall be these ancillary costs added to the routine portion of Medicare inpatient capital, adjusted for secondary payors.

(3) Allocation to payments for transfer patients and short-stay patients. Budgeted capital costs shall be allocated to payments for transferred patients and short-stay patients based on estimated non-exempt unit non-Medicare days reconciled to actual rate year days.

(f) Payment for budgeted allocated capital costs.

(1) Capital per diems for exempt units and hospitals shall be calculated by dividing the allocated non-Medicare capital costs identified in paragraph (e)(1) of this section by 1985 exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital approved capital expense.

(2) Capital payments for DRG case-based rates shall be determined by dividing the budgeted capital allocated to such rates by the hospital's most recently available annual non-Medicare, non-exempt unit discharges, reconciled to rate year discharges and actual rate year non-exempt unit or hospital-approved capital expense.

(3) Capital payments for transferred and short stay patients shall be the non-exempt hospital's average budgeted capital cost per day determined pursuant to paragraphs (2) and (3) of subdivision (e) of this section.

86-1.60 Billing provisions and limitations on changes in case mix.
(a) Billing provisions. For purposes of initial billing of governmental payors only, hospitals may bill upon admission of the patient, subject to the provisions of this section, provided, however, that the hospital submits a final bill for the patient whose DRG assignment and final payment will be determined in accordance with the provisions of this Subpart. All initial payments made based upon admission of the patient will be reconciled on discharge. Furthermore, adjustments shall be made on a quarterly basis, including any adjustements to rates of payment made pursuant to the provisions of subdivision (b) of this section.

(1) For purposes of billing upon admission for the first quarter of 1988, an initial admission payment shall be determined as specified in paragraphs (a)(1), (2), (4) section 86-1.52 of this Subpart, except that the operating cost component specified in section 86-1.52 (a)(1) shall be determined based upon a hospital specific case mix index (CMI) developed for geovernmental payors using the data used to calculate initial 1988 rates of payment.

(2) For purposes of billing upon admission for each quarter subsequent to the first quarter of 1988, an adjustment to the hospital's CMI shall be made based upon the allowable aggregate statewide increase in the hospital's CMI, as determined pursuant to subdivision (b) of this section, for the previous quarter.

(b) Limitations on changes in case mix.

(1) For rate years commencing January 1, 1994, the [~~The~~] maximum allowable increase in the non-Medicare statewide average reported case mix in an historical rate year shall not exceed, on a cumulative basis, two percent from the [~~1987~~] 1992 non-Medicare statewide average reported case mix for [~~1988~~] 1994 and an additional one percent per year thereafter from the [~~1987~~] 1992 non-Medicare statewide average reported case mix, excluding case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics or other catastrophes.

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The maximum allowable increase shall be applied to adjust rates of payment for the periods commencing January 1, 1990 and thereafter, using the following methodology:

(i) the case mix adjustment percentage determined pursuant to this subparagraph, plus the case mix adjustment percentage determined for the 1992 rate year, and further plus an adjustment to reflect the difference in measurement of the percentage change from 1992 rather than 1987 to maintain the effective maximum rate of allowable increase in non-Medicare statewide average case mix at two percent from 1987 for 1988 and one percent per year thereafter; shall be multiplied by the hospital specific average reimbursable operating cost per discharge, the group average reimbursable operating cost per discharge and the basic malpractice insurance cost per discharge and the result subtracted from such amount before application of the service intensity weight for the applicable rate year determined pursuant to section 86-1.63 of this Subpart.

(a) A reported non-Medicare statewide increase in case mix index shall be determined by dividing the statewide rate year casemix index determined pursuant to paragraph (4) of subdivision (b) of section 86-1.75 by the statewide base year case mix index determined pursuant to paragraph (2) of subdivision (b) of section 86-1.75 and subtracting one from the result.

(b) An estimated real non-Medicare statewide increase in case mix index shall be determined by dividing the estimated real rate year case mix index determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 by the estimated real statewide base year case mix index determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 and subtracting one from the result.

(c) The estimated statewide non-Medicare case mix change to be attributable to changes in coding practices shall be determined by subtracting the estimated real non-Medicare statewide increase in case mix index determined pursuant to clause (b) of this subparagraph from the reported non-Medicare statewide increase in case mix index determined pursuant to clause (a) of this subparagraph.

(d) A statewide maximum difference shall be determined by subtracting the estimated real non-Medicare statewide increase in case mix index determined pursuant to clause (b) of this subparagraph from the maximum allowable increase in the non-Medicare statewide average reported case mix as identified in paragraph (1) of subdivision (b) of this section.

(e) If the reported non-Medicare statewide increase in case mix index determined pursuant to clause (a) of this paragraph is less than or equal to the maximum allowable increase in the non-Medicare statewide case mix index as identified in subparagraph (1) of subdivision (b) of this section, the case mix adjustment percentage shall be zero percent.

(f) If the reported non-Medicare statewide increase in case mix index determined pursuant to clause (a) of this subparagraph is greater than the maximum allowable increase in the non-Medicare statewide case mix index as identified in paragraph (1) of this subdivision and the estimated real non-Medicare statewide increase in case mix index determined pursuant to clause (b) of this subparagraph is less than the maximum allowable increase in the non-Medicare statewide case mix index, the case mix adjustment percentage shall be determined as follows:

(1) The statewide maximum difference determined pursuant to clause (d) of this subparagraph shall be divided by the change estimated to be attributable to changes in coding practice for those facilities whose adjustment is greater than zero to arrive at a percentage reduction.

(2) The case mix increase estimated to be attributable to changes in coding practices determined pursuant to subdivision (e) of section 86-1.75 for those facilities whose adjustment is greater than zero shall be multiplied by one minus the percentage reduction determined pursuant to subclause (1) of this clause.

(3) The case mix adjustment percentage shall be as determined by subclause (2) of this clause for those facilities whose case mix increase estimated to be attributable to changes in coding practice determined pursuant to subdivision (e) of Section 86-1.75 is greater than zero or zero percent for all other facilities.

(g) If the reported non-Medicare statewide increase in case mix index determined pursuant to clause (a) of this subparagraph is greater than the maximum allowable increase in the non-Medicare statewide case mix index as identified in paragraph (1) of this subdivision and the estimated real non-Medicare cumulative case mix increase determined pursuant to clause (b) of this subparagraph is greater than the maximum allowable increase in the non-Medicare statewide case mix index, the case mix adjustment percentage shall be determined as follows:

[(1) an adjustment percentage shall be determined by subtracting the result of dividing the difference between the estimated real statewide increase in case mix index determined pursuant to

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clause (b) of this subparagraph and the maximum allowable increase in the non-Medicare statewide average case mix as identified in paragraph (1) of this subdivision by the estimated real statewide increase in case mix index determined pursuant to clause (b) of this subparagraph from one.

(2) the adjustment percentage determined pursuant to subclause (1) of this clause shall be multiplied by the adjusted real non-Medicare case mix increase determined pursuant to subdivision (f) of section 86-1.75.

(3) the results of subclause (2) of this clause shall be added to the case mix increase estimated to be attributable to changes in coding practices determined pursuant to subdivision (e) of section 86-1.75 to determine the case mix adjustment percentage.]

(1) The reported rate year case mix index for each hospital determined pursuant to paragraph (3) of subdivision (b) of section 86-1.75, shall be multiplied by one minus the case mix increase estimated to be attributable to changes in coding practices determined pursuant to subdivision (e) of section 86-1.75 to determine the revised rate year real case mix index.

(2) A rate year adjusted revised real case mix index for each facility shall be determined by multiplying the result of one plus the maximum allowable increase in the non-Medicare statewide average reported case mix as identified in paragraph (1) of subdivision (b) of this section divided by one plus the estimated real non-Medicare statewide increase in case mix index determined pursuant to clause (b) of this subparagraph, by the revised real rate year case mix index for each facility, as determined pursuant to subclause (1) of this clause.

(3) The case mix adjustment percentage shall be the result of one minus the result of dividing the rate year adjusted revised real case mix index for each facility, determined pursuant to subclause (2) of this clause, by the reported rate year case mix index for each hospital determined pursuant to paragraph (3) of subdivision (b) of Section 86-1.75.

(h) If the reported statewide non-Medicare increase in case mix determined pursuant to clause (a) of this subparagraph is greater than the maximum allowable increase in non-Medicare statewide case mix index as identified in paragraph (1) of this subdivision and the estimated real non-Medicare case mix determined pursuant to paragraph (6) of subdivision (b) of section 86-1.75 is equal to the maximum allowable increase in non-Medicare statewide case mix index, the case mix adjustment percentage shall equal the case mix increase estimated to be attributable to changes in coding practices determined pursuant to subdivision (e) of section 86-1.75.

(ii) A hospital may appeal the estimate of its real cumulative case mix increase for the rate year pursuant to the provisions of sections 86-1.61 of this Subpart. The case mix adjustment percentage determined in accordance with [illegible] shall be recalculated only subsequent